Collaboration between home care staff, leaders and care partners of older people with mental health problems: **a focus on personhood**

Aim: To explore home care staff and leaders' experiences of collaborating with care partners of older people with mental health problems through a personhood perspective.

Background: Collaboration with care partners is a political aim in recent white papers in Norway and internationally. Home care services regularly work closely with care partners, but there are many indications that the collaboration does not work satisfactorily.

Methods: The study had a qualitative design and comprised eight health professionals in two focus groups and in-depth interviews with three leaders in one home care district. The data were analysed using a thematic framework analysis building on previous research on personhood. COREQ reporting guidelines were used to ensure comprehensive reporting.

Results: Four themes were identified in the analysis: 'Non-negotiated relationships', Contradictory agendas', 'Weak paternalism' and 'Moral compromise'.

Conclusion: There seems to be a lack of facilitation of collaborative relationships through all levels of the home care organisation. The interactions between care partners and home care staff sometimes appear to produce low or negative levels of emotional energy, and situations where the personhood of neither of them is respected occurs. Paying attention to the four modes of being as a framework for understanding personhood, creates the foundation for a person-centred approach that enhances the potential of creating stronger partnership in care relationships.

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Keywords: Older people, home healthcare services, caregivers, collaboration, nursing, personhood.

Introduction

Home care services have gained an increasingly important role in primary care over the last decades (1, 2). Home care staff work closely with care partners, but there are many indications that the collaboration does not work satisfactory (3). Although there is a lot of general knowledge in this field, little is known about the collaboration between care partners of older people with mental health problems and home care services (4). The knowledge that exists, however, suggests that care partners of older people with mental health problems are similar to the care partners in other caring situations in that they have a need for information, shared decision making, and support services, and that these are often not considered (5, 6). Recent white papers in Norway emphasize collaboration with care partners (7, 8). In order to enable partnership working as a foundation for collaboration between home care services and care partners of older people with mental health problems, knowledge about existing collaboration is needed. This paper will explore home care staff and leaders' experiences of collaborating with care partners of older people with mental health problems through a personhood perspective.

Background

The Norwegian Coordination Reform has placed a focus on coordination and collaboration between primary and specialist levels of the Norwegian healthcare system (9[1]). In the report in which the Coordination Reform is grounded, the efforts of care partners are recognised, and better interaction with care partners is a goal (9, p. 57). This correlates with a general contemporary political focus on care partners worldwide (7, 8). It might be said that a 'coordination reform' is in progress in most industrialised countries, and that the common thread between them is a greater emphasis on primary healthcare (10) provided in local communities. In Norway, as more health tasks are transferred to the municipalities, home care staff are taking on more complex tasks and assuming greater responsibility. Accordingly, an increasing number of older people are receiving necessary healthcare in their own homes, which again affects the lives of care partners (11). More responsibility is being placed on care partners and the private sphere of home and everyday life is being broken down through continuous visits from many different home care staff members – for many, on a 24-hour basis (12). It has

[1] Provides an English summary of the reform.

been stated that municipalities should offer individually tailored support, relief, training and guidance to care partners (8), but research suggests that both older people with mental health problems and their care partners receive poor attention from the municipal health care system (13). Research also shows that home cares services do not involve care partners sufficiently: there is a lack of communication and few or no routines for collaboration exist between home care and care partners of older people with mental health problems (14).

The term 'mental health problems' cover a wide range of conditions where the most common diagnoses are depression and anxiety disorders (15). Several older people are affected by these disorders, but receive restricted governmental help (4, 13). Health care is often first offered when a somatic disease occurs, which means that care partners may have provided care for years without help. When home care services initiate health care, the mental health needs of the person are often not prioritized (5, 13) and thus remain the care partners' responsibility. When these persons get insufficient help, this also affects their care partners (4, 5). The relationship between formal and informal care has been conceptualised in different ways (16), conventionally in a perspective about how professionally registered carers (home care staff) and un-registered carers (the care partners) collaborate in meeting needs, clarifying roles and agreeing responsibilities (17, 4). This study offers a new approach, where the home care staff and leaders' experiences of collaboration with care partners of older people with mental health problems are explored through a personhood perspective. This approach to the research adopts a philosophical position of whole equal partners of all persons in the provision of services and meeting individual care needs.

Personhood

Worldwide, person-centredness has been established as a strategic focus in healthcare policy and in professional practice (18). The concept of 'person' or 'personhood' is central to person-centredness and the concept of person and its implications for how people should be treated embraces several disciplines and has been debated for centuries (19). Attributing the title of 'person' entitles the holder to certain moral, ethical and legal rights. Attributes such as cognition (intelligence, rational decision making), the capacity for understanding/speaking language, consciousness, free will, creativity, the ability to make moral judgments, self-awareness and the existence of a soul have been suggested (20, p. 23). Whether one is considered to be a person or not is central in controversial morally challenging issues, such as the death penalty, abortion and euthanasia. However, whilst these issues are major societal dilemmas, in the provision of

healthcare, consideration of the status of persons also effects the ways in which healthcare is designed, delivered and received and these same attributes need to be considered. Entwistle and Watt (19) argue that the status of patients as persons is fundamental to person-centred care and is best articulated through an ethical focus on patients being treated as 'persons'.

The study reported on in this article is based on a framework developed by McCormack (21), which in turn is based on Kitwood's definition of personhood:

> a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust. Both the according of personhood, and the failure to do so, have consequences that are empirically testable. (22, p. 8)

Through this perspective comes the understanding that having an awareness of the concept of personhood affects how people relate to each other. However, we need to exercise caution when positioning personhood through a relational perspective. If a person's personhood is dependent on recognition by others, then clearly this poses potential limits on personhood as an absolute moral value. Numerous situations can be identified wherein one person does not engage in a morally equal relationship with another and thus erodes the other's personhood/status as a person.

The four modes of being

McCormack (21) claimed that Kitwood's definition of personhood could also be seen as a definition of person-centredness. Out of the definition, McCormack extracted four core concepts, which he argued, are at the heart of person-centred nursing: being in relation, being in a social world, being in place and being with self (21, p. 33). These concepts were used as the foundation for the analytical framework in this study, with a particular focus on personhood. In this study, person-centredness is seen as the operationalizing of personhood, and the relationship between the two concepts can be seen in Table 1. These concepts are presented as the starting point for the study.

Being in relation

Being in relation is about the importance of relationships and processes that help achieve therapeutic outcomes (23). Traditionally, the nurse–patient relationship has been regarded as the central focus, but there is an increasing awareness of the care partners' role in this relationship (24, 25). In this study, 'being in relation' is used to shed light on all relational issues between care partners and home care staff.

Being in a social world

Biography, a person's life story, is a key word when it comes to *being in a social world*. Having an understanding of the person's context, background, values and preferences lays the foundation for a caring relationship that nurtures individual personhood (21) and also highlights the central role of care partners. Furthermore, a biographical approach has been found to support the development of care partner–care staff partnerships (26). This connects with the social set up for care delivery and the care partners' context in this study.

Being in place

According to McCormack and McCance (18), the influence that physical place has on the overall care experience for patients is increasingly recognised but still under-researched. They argue that the qualities of the environment in which care is provided have an impact on the care experience, and that the emotional connections people have with places should therefore be taken into consideration (18). Transferred to this study's context, 'being in place' concerns how home care staff pay attention to place and environmental factors.

Being with self

This concept places emphasis on respect for values. Insight into what patients and their care partners value and how they make sense of the things that happen to them form the foundation for negotiated decision-making (21). McCormack and McCance (18) suggested that care staff need to have an awareness of 'self' and how their own values and beliefs can impact on decisions made about a patient's care and treatment (23, p. 31). This is also applicable to care partners. They are affected by how their values are respected in the care process and to what extent they are involved in decisions that concern themselves, the patient and their shared homes. The connection with this study lies in the way the data gives voice about values, shared decision making and awareness of the self.

Table 1. Schematic overview of the link between the framework and the study, and steps in the analysis.

Analytical Framework			**The Steps of Analysis**			
Concept Person-centredness[2] (Codes)	**Link with Kitwood's Definition of Personhood**	**Link with this Study (Descriptions)**	**Analysis - Leaders**	**Analysis - Staff**	**Analysis - Leaders/Staff Merged**	**Themes**
Being in relation	Persons exist in relationship with other persons	Relationships on micro level, between leaders, homecare staff and care partners	Asymmetric relations Lack of standardisations	Unspoken expectations	Asymmetric relations Unspoken expectations	Non-negotiated relationships
Being in a social world[3]	Persons are social beings	The social setup framing the collaborative relationships, and how the care partners' context is understood	Lack of recognition of the care partners' social set up Operating in different social worlds	Organisational factors limit involvement To be treated as a person	Operating in different social worlds Acknowledgement of personhood	Contradictory agendas (organisation-staff-care partners)
Being in place	Persons have a context through which their personhood is articulated	The arena for the care relationships and environmental factors	Paternalistic attitudes Leaders as mediators	Bureaucratic processes	Leaders as mediators	Weak paternalism
Being with self	Being recognised, respected and trusted as a person impacts a person's sense of self	The espoused and lived values. How the individuals are understood as persons. Roles and understanding of roles	Contradictions between espoused and lived values	Working with values Building trust Customised care	Contradictions between espoused and lived values Working with values and building trust	Moral compromise

[2] 21, p. 33.
[3] In further developed versions of the four modes of being (18, 23), the term 'social world' has been changed to 'social context'. The original term is used here to prevent confusion between being in a social world and being in place, as both in different ways concern context.

THE STUDY

Aim

The aim of this study was to explore home care staff and leaders' experiences of collaborating with care partners of older people with mental health problems through a personhood perspective. The focus is thus on collaboration in a personhood perspective, and not on collaboration per se. The study aimed to answer the following research question:

> *How can a focus on personhood help to make sense of the nature of the collaborative relationship between home care staff, leaders and care partners?*

Methods

The study took a qualitative approach and was based on the consolidated criteria for reporting qualitative research (COREQ) reporting guidelines (27). The data were analysed using Framework Analysis (28) building on previous research on personhood (21).

Participants

The setting was one rural home care district located in the south-eastern part of Norway. Initially, two information meetings were held. The participants were informed about the goal of the project, and were introduced to basic theories of person-centred healthcare, as this was an underpinning approach in both the study and the research process. After the information meetings, 11 people signed up for participation in the study; three leaders to in-depth interviews and eight home care staff members to focus group interviews[4]. The three leaders agreed to participate during the meeting, while the home care staff who wanted to participate gave notice to their leader shortly after. All who wanted to participate in the study were included. In-depth interviews were chosen for the leaders due to the asymmetric power relations between the leaders and home care staff. Characteristics of the participants are presented in Table 2.

Table 2. Demographic characteristics

Participants		*N* = 11
Age	**Range**	25–65
Sex	**Male**	0
	Female	11

[4] No further detail on the mix of professions in the two focus groups are provided in order to protect the anonymity of the participants regarding their co-workers.

Profession	**Nurse**	4
	Nurse assistant	4
	Leader	3
Years of experience in home care services	**Range**	1–28 years

The inclusion criterion for participation in the study was employment in home care services as either care staff or leader.

Data collection

The study comprised eight health professionals in two focus groups and in-depth interviews with three leaders in home care services. The interviews were conducted in the home care services office. The focus groups interviews were based on Malterud's (29) approach, which intends to stimulate discussion and bring out different perspectives through the group dynamic. The participants were encouraged to talk freely together about the asked questions, in which they did. It often is recommended that focus groups are led by two persons, a moderator and a secretary/observer (29), however, this was not done in this study. The focus groups were relatively small, with four participants in each, and it was considered that the presence of two researchers could inhibit the discussions. Thus, the main author moderated the discussions and did observations that were written down shortly after the interviews. Two interview schedules were prepared, one for the focus group interviews, and one for the in-depth interviews, with some similarities, see table 3 for examples of the asked questions. However, there was flexibility to explore issues that came up in the interviews and follow-up questions were frequently used. The interviews lasted approximately one hour and were audio-taped and transcribed verbatim.

Table 3. Examples of questions in interview schedules

Focus group interviews	In-depth interviews
What do you think when you hear the terms care partner collaboration?	What do you think when you hear the terms care partner collaboration?
How do you experience the collaboration with care partners?	How do you experience the collaboration with care partners?

In which way do you think home care can support care partners?	How often are you in touch with care partners?
What kind of care is given to care partners?	What formal routines do you have for collaboration with care partners?

Data analysis

The data were coded and analysed according to the framework method (28) (Table 4). This method belongs to a wide-ranging group of analysis methods often labelled thematic analysis or qualitative content analysis. In this study, the initial codes were developed deductively from an existing theoretical framework (21), while the themes were grounded in the pre-defined codes but further developed inductively.

Table 4. The framework method analysis process

The framework method analysis process
Transcription Verbatim transcription of the interviews was completed.
Familiarisation with the interview The interviews were read and reread by the first and last author (C. A-H & S. T). The other authors (B. M & K. S) read a large selection of key quotes from all the interviews. The first impressions of the data material were discussed, and all members of the research group became familiar with the data.
Coding The codes were pre-defined based on the research question and the theoretical framework of McCormack (21). This stage constituted the deductive part of the analysis. The code manual consisted of four code categories (being in relation, being in a social world, being in place and being with self).
Developing a working analytical framework In this stage, a description of how the codes should be translated into this study's context was drafted. After a discussion in the research group, the first author formed the final descriptions of the links between the codes and the current study (Table 1). A set of questions, based on literature on 'the four

modes of being' (18, 21, 23) was outlined to help extract meaning from the data material (Table 4). Together, this formed the analytical framework.
Applying the analytical framework The next step was to apply the analytical framework to the transcripts, where appropriate codes were applied to meaningful passages of the text.
Charting data into the framework matrix Once all the relevant data were identified with a related code, they were put into a matrix as verbatim meaningful passages of the text. These passages were then summarised and abstracted at the end of all columns. The summaries were divided into two categories: factors that help and factors that hinder. The latter procedure was a suitable tool for gaining thorough insight into the material.
Interpreting the data The abstracted material from all the leaders and staff was merged before the final generation of themes. Both the theoretical framework and the inductive process that generated new concepts from the data influenced the generation of themes. In accordance with Gale, Heath, Cameron, Rashid and Redwood (28), different ideas were discussed within the research team with the goal of getting beyond individual cases in order to develop themes.

Table 5 illustrates the questions that were used to extract meaning from the data material. It is worth noting that even though this has been described as a linear procedure, the actual analysis was a cyclical process, characterised by back-and-forth movement between the different stages.

Table 5. Illustration of questions used to extract meaning from the data material

Being in relation	**Being in a social world**	**Being in place**	**Being with self**
1. How do care partners and home care staff nurture their relationship?	1. What is the social set up of the care delivery for the care partner?	1. How do the care partners and home care staff pay attention to place and environmental factors?	1. What do the data tell us about beliefs and values; to what degree is there awareness of 'self'?

2. What are the relational issues?	2. What efforts are made to understand the care partner's context and assess what is of importance to each person?	2. How are the power relationships articulated?	2. What do the data tell us about shared decision making?
3. Are the relations based on mutual trust and mutuality, and are they non-judgemental?		3. What are the organisational values, systems of decision making, staff relationships and organisational systems?	3. Are there commonalities between the values of care partners and care providers?

Preunderstandings

This current study was completed as the first author's PhD research. Three of four members of the research group have a professional background in home care services. This enabled a comprehensive understanding of the general conditions experienced by home care staff, but the preunderstandings could significantly affect the exploration of the data material. In order to reduce the risk of bias, awareness of this concern was an important prerequisite throughout the research process. The first author wrote down personal reflections regarding her preunderstandings, and discussed them with the research group. Furthermore, a transparent presentation of the research process was sought. The research groups' main preunderstanding was that care partners have received scarce attention from home care services. The main prejudice was that the collaboration between home care services and care partners is not working optimally.

Ethical consideration

The project was reported to the Norwegian Centre for Research Data (NSD). Permission to conduct the study was provided by the head of the home care services, and the further consent process was guided by the principles of the Helsinki Declaration (WMA). Information about the project was provided in both oral and written form and included participant anonymity and

confidentiality, as well as the participants' right to withdraw from the study at any time for any or no reason. All the participants gave their written consent. The data material was treated according to NSD's recommended procedures.

FINDINGS

The findings are presented according to the four modes of being (21), with themes, in Table 6 below.

Table 6. Findings

Themes			
Being in relation	Being in a social world	Being in place	Being with self
Non-negotiated relationships	Contradictory agendas	Weak paternalism	Moral compromise

1. Being in relation - Non-negotiated relationships

The relationships between the care partners, home care staff and the leaders can be characterised as asymmetric. The top manager illustrates this when talking about the leaders 'under' her, and "my department leaders":

> *Obviously, if the leaders, my department leaders, do not focus on interacting with these care partners, then team leaders and other nurses and healthcare workers will not have the same focus either* (...) *As a top leader, I have to make sure that I have department leaders under me who do their job.* (Leader 2)

One participant labelled the organisation as hierarchical, which can also be seen as an expression of asymmetry in the relationship between colleagues with different professions whereby the nurses ranked higher than, for example, an assistant nurse:

> *I also think it's too ... (...) a bit hierarchical because it's like, it is the nurses who have to fix things*. (Leader 3)

The quote indicates that the nurses have a superior responsibility within the organisation, without this necessarily being a stated strategy, but more of a way in which the work is organised on a daily basis.

When the staff talked about the relationship with care partners, it was mainly in positive terms, and disagreements seemed to stem from unspoken expectations:

> *they do not quite understand how we work, and then they think perhaps that we can get there (laughing) immediately ... like in two minutes ... yes, preferably we should have been there yesterday.* (FG2, staff member 3)

However, the staff were self-critical when it came to continuity in their work, the lack of a systematic approach towards collaboration, and the lack of information and education.

2. Being in a social world - Contradictory agendas

When the leaders and staff talked about topics related to this theme, the focus was mainly on their own social worlds. It appears that there was a lack of understanding for the care partners' world, despite their services often taking place in the care partner's own homes. The care partners were 'invited in' for collaboration, while the organisational factors placed significant limitations on the collaboration. This concerns for example, the ability of staff to fully enter the care partners' world and to meet them as equal partners in a collaborative relationship:

> *You know, the care partners have expectations, and deep down inside you really want to help, but then you have the commitments* (to the organisation)*, which can be difficult for the care partners to understand.* (FG1, staff member 3)

To be treated as a person was a recurring topic. These reflections seem to deal with the dividing line between the home care staff as professional practitioners (objects) and as persons behind their titles (subjects). One example of this is how the home care staff expressed that it was easier to be service-minded towards positive care partners:

> *Most of the time, the care partners are very, very happy with us and of course then we perhaps put in a bit more effort, a little bit extra you know, as you grow a bit when you get some positive feedback.* (FG2, staff member 2)

Opposite, negative feelings were also felt in the meeting with care partners. One home care staff member compared this experience to being used as a garbage can:

> *It's often like that when they get tired, that's the way.... You're a garbage can.* (FG1, staff member 1)

However, the home care staff also showed understanding towards the more negative attitudes among care partners, but appreciated an explanation or apology for these attitudes.

3. Being in place - Weak paternalism

The main relational role of the leader in home care services seemed to be as a mediator between staff and care partners. A common procedure was that the leader stepped in when challenging situations occurred between care partners and staff:

> *They (*the staff), *have to go out and try themselves. But if there is uncertainty, things that are difficult or can be uncomfortable, then I think it's natural that I contribute as a support, if they want it. And if there are things I feel I cannot grasp or see the context of, I have also gone home* (to the patients/care partners) *myself.* (Leader 1)

This quote can also be seen as an expression of paternalism, a father-like leadership style where authority is combined with concern and consideration (30). Regarding the collaborative relationship between leaders and care partners, contours of a power relationship can be seen whereby the leaders had a high degree of authority when it came to decision-making processes:

> *So here it is the total package that determines whether we feel it is appropriate to provide respite in the home (....) if we believe it is correct then the respite is given at the nursing home* (Leader 2)

This quote illustrates how it is decided whether respite care would be provided at the nursing home or in the patients' home. Furthermore, a member of the home care staff expressed that she did not wish to collaborate with care partners when caring for the patients:

> *Sometimes I think that it would be very nice if the care partners could go out, go away, take a trip somewhere so we can get the job done in peace*. (FG2, staff member 4)

Others in the focus group agreed to this statement. The staff also signalled through their attitudes in some situations that they were superior care partners and had overall responsibility in decision-making processes.

4. Being with self - Moral compromise

Both the leaders and staff talked warmly about the importance of a value-based collaboration. However, there seemed to be dissonance between this espoused value and the lived values in many situations. The recipe for a successful relationship was acknowledged, but its implementation seemed to be a challenge:

> *I think it's important that we talk about attitude, important to all (...) how to behave in a home towards care partners (...) Yes, and I think we have a long way to go (...).* (Leader 3)

This quote also illustrates that there was an awareness of shortcomings in this area. However, there was also an attitude that the care partners asked for too much from the home care services:

> *We often find that they may ask for a bit too much and it is more about them, that they are anxious, they do not feel safe but as I say, we are the professionals who must understand why they react as they do (...)* (Leader 2)

What was prominent, was the willingness to work with values. Nevertheless, it appears that the organisational framework did not facilitate the exercise of the profession in accordance with the values of staff and their preferences:

> *I just have to think that now I'm here, now I have to do what I'm going to do here, then you run out or I run out (...) you can't do it any other way, it's just the way it is*. (FG2, staff member 4).

This quote illustrates how time constraints place limitations on the degree of involvement that was possible for the home care staff. Several times in the interviews there were also expressions of things home care staff wanted to do, like making coffee or sitting down for a chat, but which had to be excluded due to organisational rules and/or lack of time.

DISCUSSION

The themes identified in the analysis all represent the complexity of collaborative relationships. This raises some significant issues related to the nature of collaboration and the importance of acknowledging personhood for both care partners and home care staff.

It is argued that organisational culture is fundamental to person-centred care (31). However, the analysis suggests that person-centred values are not strongly embedded in home care services. The way leaders talk about their relationship with both the staff and the care partners is characterized by paternalism, and not in ways that reflect person-centred values. Furthermore, both the leaders and staff talked warmly about collaboration with care partners but it seems like this was espoused and not transformed into action on a daily basis. If the personhood of the home care staff is not respected in their work culture and context, it can be difficult to advocate these values in meetings with both care partners and patients (18). Some of the staff expressed a willingness to provide more care for the care partners, whereas others thought they were asking for too much. Regardless of the approach, the result was the same: the care partners were left in the shadow of the patients, without a recognised role in the interaction. Bonding between people depends on mutual trust, which is usually connected to emotional and intellectual ties (32, p. 11). This can be seen in the light of Collins' interaction ritual theory (33). The theory focuses on the importance of interaction rituals, emotional solidarity and the concept of emotional energy (EE) (34). According to Collins (33), EE is '…a continuum, ranging from a high end of confidence, enthusiasm, good self-feelings; down through a middle range of lesser states, and to a low end of depression, lack of initiative, and negative self-feelings' (p. 32). We connect the four modes of being (21) with Collins' interaction ritual theory (33), in order to

offer a potential rationale for ineffective collaboration between care partners and home care staff.

The first mode of being, *being in relation*, can be seen as fundamental for developing a well-functioning collaboration. How people are met and recognised in relationship with others concerns how their personhood is respected (23). Honneth (35) claimed that a person's normative self-image is dependent on being confirmed by others, and that recognition is a fundamental need for all people. This also applies to home care staff. Entering a professional role does not mean that the need for recognition and emotional connection is automatically set aside (36). However, when there are scarce interactions between home care staff and care partners, to establish mutual relationships based on trust and respect for each other's personhood is challenging. If the emotional connection is absent it can be difficult for the staff to develop real emotion through "deep acting" while interacting with the care partners, which results in the use of "surface acting" (36, 37). This may lead to a display of empathy that is "effectively deceptive and can be dehumanizing for both parties" (37, p. 37). As a result, this can produce negative emotions and/or low levels of emotional energy: the care partners can feel unworthy of natural empathy, and the home care staff can feel guilt and shame for not being able to produce authentic empathy (33, 36, 37). As we can see from the analysis, little is done to nurture the relationship between home care staff and care partners. There are few signs of the relationships being based on mutuality and trust, and there is a high probability that low levels of EE are being produced in their meetings. If the core values of "being in relation" is not established in the relationship, we can see a cumulative, negative effect impacting on the remaining modes of being, as is argued here.

In the next mode of being, *being in a social world*, we can see in the data how there was limited care delivery for the care partners and few efforts were made to understand the care partner's context and assess what was of importance to each person. Based on a challenging or non-existent relationship it is difficult to have an understanding of the care partners' context, background, values and preferences. When the first mode of being is not established, this can hinder access to the care partners' life world. The consequence is again possible low levels of EE. The same can be assumed to happen when it comes to *being in place*. When there is no established relationship with the care partners and the staff have limited access to their life world, it can be difficult to have an understanding of the importance of place. One result of this can be seen in the data; some of the home care staff wanted the care partners to leave their own

house while they were providing care to the patient. Human beings feel attracted to successful encounters and avoid, where possible, encounters where unsuccessful interaction rituals are expected (33, 38), and by avoiding meeting the care partners, the home care staff could avoid getting low levels of emotional energy. Regarding *being in place*, it was also seen how one of the leaders claimed that it was up to the leaders to decide where it was appropriate to offer respite for the patients. The care partners were not a part of this decision, despite the matter of place most likely had an impact on their daily life. This can be seen as a devaluation of the importance of both the concept of place and inclusion of care partners in decision-making processes. The last mode of being, *being with self*, emphasizes how recognition, respect and trust impacts a person's sense of self (22). It is reasonable to conclude that if the previous categories are not realized, it will be nearly unmanageable to create a 'negotiated' approach between the staff and care partners, characterized by recognition and trust. Situations may then appear where the personhood of neither of the parties are respected, and the emotional levels are in danger of not only getting drained, but also turning negative.

Whilst Collins' theory helps to provide a rationale for ineffective collaboration and lack of respect for personhood, it is argued that Collins' theory lacks a dimension (34). Boyns and Lurey (34) believe that since Collins focused primarily on positive emotional energy, the model lacks an expression of 'the ritual dynamics of the dark-side of emotional experiences' (34, p. 149). They asked what kind of energy is produced on the basis of negative emotional experiences and launched the idea of negative emotional energy (EE-), where low levels of EE- result in feelings like avoidance and irritation. This challenge by Boyns and Lurey resonates with the findings of this study. We can see how some of the interactions between home care staff and care partners contributed to draining EE and generating EE-. In applying this to the four modes of being, it can be said that EE- is "the skunk at the picnic": If it occurs in the establishment of the relationship between home care staff and care partners, the emotions that EE- generates will make it difficult to achieve success in the other modes of being. To form the base for a good, equal relationship, it should be acknowledged that both home care staff and care partners are moral equals, who need to be respected and to have the opportunity to gain energy in their meetings (37, 39).

CONCLUSION

This study set out to answer the question of whether a focus on personhood could help make sense of the collaborative relationship between home care staff and care partners. The results

illustrate the complexity of this phenomenon. There seems to be a lack of facilitation of collaborative relationships through all levels of the home care organisation. The interactions between care partners and home care staff appear to frequently produce low or negative levels of emotional energy, and situations occur where the personhood of neither parties is respected. Paying attention to the four modes of being through a person-centred approach increases the potential of creating stronger partnerships in these care relationship. In turn, this can lay a foundation for interactions between leaders, home care staff, care partners and patients that generate positive EE.

LIMITATIONS

Our study has some limitations that should be acknowledged. First, in the analysis process it was occasionally difficult to distinguish between whether the participants talked about care partners of older people with mental health problems, or care partners in general. However, we see this as a finding in itself: care partners of older people with mental health problems are not visible in the care landscape. It confirms and reinforces the need for more research in this field. Second, the data is collected in one home care district. If several districts were included, other aspects might have been covered. Third, due to the design of the study, the results cannot be generalized, but we do believe they have transferability to other contexts. However, the results can help to see relational aspects between care partners and home care services from a new perspective, regardless of the diagnoses of the patient.

References

1. NOU (2011:17). *Når sant skal sies om pårørendeomsorg* [The truth about care for care partners]. Oslo: Helse- og omsorgsdepartementet.
2. Keeling DI (2014) Homecare user needs from the perspective of the patient and carers: a review. *Smart homecare technology and telehealth* **2**, 63-76.
3. Tønnessen S. *Pårørende: Usynlige bærebjelker i velferdsstaten* [Care partners: Invisible pillars of the welfare state] I Vike H, Debesay J, Haukelien H (Eds.) Tilbakeblikk på velferdsstaten. Politikk, styring og tjenester. Gyldendal Akademisk: 2016.
4. Briseid KM. *On the old and the new. An ethnographic study of older people's mental health services in a changing welfare state*. Kongsberg. University College of Southeast Norway; 2017.
5. Anker-Hansen C, Skovdahl K, McCormack B, Tønnessen S. The third person in the room: the needs of care partners of older people in home care services. A systematic review from a person-centred perspective. *J Clin Nurs* 2017; 27:e1309-1326.
6. Whitlatch CJ, Orsulic-Jeras S. Meeting the informational, educational, and psychosocial support needs of persons living with dementia and their family caregivers, *Gerontol* 2018; 58:58-73.
7. Helse - og omsorgsdepartamentet. (2013). Meld.St.29. Morgendagens omsorg. [Future care] Available from: https://www.regjeringen.no/contentassets/34c8183cc5cd43e2bd341e34e326dbd8/no/pdfs/stm201220130029000dddpdfs.pdf
8. Helsedirektoratet. (2017). *Veileder om pårørende i helse- og omsorgstjenesten*. [Guidance for care partners in the health and care services] Available from: https://helsedirektoratet.no/Retningslinjer/Pårørendeveileder.pdf
9. Report No. 47 (2008–2009) to the Storting. The coordination reform. Oslo: Norwegian Ministry of Health and Care Services; 2008 [Summary in English]. Full version in Norwegian. Available from: https://www.regjeringen.no/en/dokumenter/report.no.-47-to-the-storting-20082009/id567201/?ch=1&q=#?ch=1&q=&_t_dtq=true&_suid=1460376928432043690 84028942121
10. Grimsmo A, Magnussen J. *Norsk samhandlingsreform i et internasjonalt perspektiv.* [The Norwegian collaboration reform in an international perspective]. Institutt for samfunnsmedisin. Norges Forskningsråd: NTNU; 2015.
11. Carlsen B. *Samhandlingsreformens konsekvenser for eldre: pasientrettigheter, pårørende og koordinering av tjenester*. [Impact of the collaboration reform on older people: patient rights, care partners and coordination of services]. Forskningsrådet: Uni Research AS; 2016.
12. Fjørtoft A-K. *Hjemmesykepleie. Ansvar, utfordringer og muligheter.* [Home care. Responsibilities, Challenges and Opportunities]. Fagbokforlaget: Bergen; 2009.
13. Skatvedt A, Andvig E, Baklien B. Bakkebyråkratiets yttergrense. Hjemmetjenestens møte med eldre med psykiske helseproblemer [Street level bureaucracy's outer limit. Home care service's meeting with elderly people with mental health problems.]. *Nordisk Tidsskrift for Helseforskning* 2015; 11, 20-34.
14. Anker-Hansen C, Skovdahl, K, McCormack, B, Tønnessen, S. Invisible cornerstones: a hermeneutic study of the experience of the care partners of older people with mental health problems in home care services. *Int J Older People Nurs*. 2018.
15. Reneflot A, Aarø LE, Aase H, Reichborn-Kjennerud T, Tambs K, Øverland S. Psykisk helse i Norge [Mental health in Norway], Folkehelseinstituttet. Rapport 2018. Available from: www.fhi.no

16. Büsher A, Astedt-Kurki P, Paavilainen E, Schnepp W. Negotiations about helpfulness – the relationship between formal and informal care in home care arrangements. *Scand J Caring Sci* 2011; 225, 706-715.
17. Aasgaard HS, Dish PG, Fagerström L & Landmark BT. Pårørende til aleneboende personer med demens. [Care partners of older people with dementia living at home]. *Nordisk sykeplejeforskning* 2014; 2, 114-128.
18. McCormack B, McCance T (editors). *Person-Centred practice in nursing and health care. Theory and practice.* West Sussex, UK: Wiley Blackwell; 2017.
19. Entwistle A. V, Watt I. S. Treating patients as persons: a capabilities approach to support delivery of person-centred care. *Am. J. Bioeth.*2013; **8**: 29-39.
20. Dewing J, Eide T, McCormack B. Philosophical perspectives on person-centredness for healthcare research. In: McCormack B, Dulmen S. V, Eide H, Skovdahl K, Eide, T, editors. *Person-centred healthcare research.* UK: Wiley-Blackwell; 2017
21. McCormack B. Person-centredness in gerontological nursing: an overview of the literature. *J Clin Nurs* 2004; 13:31-38.
22. Kitwood T. *Dementia reconsidered: the person comes first.* Berkshire: McGraw-Hill Education; 1997.
23. McCormack B, McCance T. (2010). *Person-Centred Nursing. Theory and practice.* Wiley-Blackwell, Oxford; UK; 2010.
24. Eldh AC, Luhr K, Ehnfors M. The development and initial validation of a clinical tool for patients' preferences on patient participation – the 4Ps. *Health Expect*. 2014. DOI:10.1111/hex.12221.
25. Landmark BT, Aasgaard HS, Fagerström L. To be stuck in it—I can't just leave: a qualitative study of relatives' experiences of dementia suffers living at home and need for support. *Home Health Care Manag Pract* 2013; 25:217-223.
26. Kellett U, Movle W, McAllister M, King C, Gallagher, F. Life stories and biography: a means of connecting family and staff to people with dementia. *J Clin Nurs* 2010; 19:1707-1715.
27. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19:349-357.
28. Gale NK, Heath G, Cameron E, Rashid S, Redwood, S. *Using the framework method for the analysis of qualitative data in multidisciplinary health research.* BMC Medical research Methodology 2013; 13:117.
29. Malterud, K. (2012). Fokusgrupper som forskningsmetode for medisin og helsefag [Focus groups as research method for medicine and health sciences]. Oslo, Norway: Universitetsforlaget.
30. Westwood R, Chan A. Headship and leadership. In: Westwood R, editor. *Organisational behaviour: Southeast Asian perspectives*. Hong Kong: Longman; 1992, 118-143.
31. Kirkley C, Bamford C, Poole M, Arksey H, Hughes J, Bond J. The impact of organisational culture on the delivery of person-centred care in services providing respite care and short breaks for people with dementia. *Health Sos Care Community* 2011;**19**: 438-448. doi: 10.1111/j.1365-2524.2011.00998.x.
32. Scheff TJ. *Microsociology.* Chicago. Chicago, University Press; 1990.
33. Collins R. Stratification, emotional energy, and the transient emotions. In: Kemper TD, editor. *Research agendas in the sociology of emotions*. Albany: State University of New York Press; 1990
34. Boyns D, Lurey S. Negative Emotional Energy: a theory of the "Dark-Side" of Interaction Ritual Chains. *Soc. Sci.* 2015; **4**:148–170; doi:10.3390/socsci4010148
35. Honneth A. Kamp om anerkjennelse. [Struggle for recognition]. Pax Forlag: Oslo; 2008.

36. Hochschild A. *The managed heart: Commercialization of human feeling*. California: University of California Press;1993.
37. Buetow S. Person-centred health care. Balancing the welfare of clinicians and patients. Routledge, New York; 2016.
38. Falch, W. *Står til tjeneste. Emosjonelt arbeide i tjenestemøtet*. [At your service – Emotional labour in service encounters]. Karlstad: Karlstad University Studies; 2010.
39. McCormack B, Skatvedt A. Older people and their care partners' experiences of living with mental health needs: a focus on collaboration and cooperation. *J Clin Nurs* 2016; 26:103–114.